VISN 5 MIRECC Research Abstract

Behavioral Treatment of Drug Abuse in SPMI Patients
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Drug and alcohol abuse by people with severe and persistent mental illness (SPMI) is one of the most significant problems facing the public mental health system. Lifetime prevalence rates exceed 50%, and substance abuse among SPMI patients is associated with a host of deleterious consequences, including unstable housing and homelessness, family conflict, financial problems, legal problems, increased rates of medical morbidity, non-compliance with treatment, relapse and rehospitalization, and physical and sexual victimization. There is an extensive literature on treatment of dual disordered patients, and there is a broad consensus on a number of principles required for effective treatment, including: a) the need for integrated psychiatric and substance abuse treatment, b) the need to conceptualize treatment as an ongoing process in which motivation to reduce substance use waxes and wanes, and c) the assumption that a harm reduction model is more appropriate than an abstinence model, especially during the early stages of treatment when the patient has uncertain motivation to change. Despite agreement on the structure of treatment programs, there is a dearth of empirical data on effective techniques for producing change, and no approach meets criteria for an evidence based practice.

We have been conducting a Stage 1b project to develop a new, multifaceted treatment for substance abuse in dual disordered patients that addresses the specific problems and needs of this population. Consistent with NIDA guidelines for a Stage 1b project: a) we have completed development of our intervention, Behavioral Treatment for Substance Abuse in Severe and Persistent Mental Illness (BTSAS), and produced a detailed manual; b) pilot tested a standardized reference treatment, Supportive Treatment in Addiction Recovery (STAR); and c) conducted a randomized trial comparing the two. The preliminary outcome data are very promising, and suggest that the treatment is well-accepted by patients and has a significant effect on drug use. Based on this pilot, we now propose to conduct a larger, Stage 2 trial to evaluate the effects of the current, refined iteration of BTSAS.

While BTSAS was effective at retaining subjects and fostering reduced drug use, a major problem we encountered in our trial was low rates of engagement. Of 287 patients who provided Informed Consent for our study 76 (26.4%) failed to complete Baseline assessments. Of the 182 (diagnostically eligible) subjects who completed Baseline assessment, 62 (34%) failed to become engaged in treatment (i.e., attended more than 2 sessions). Thus, overall, 53.5% of (eligible) consenting patients failed to become engaged. This rate of pre-engagement attrition is quite common in the field and appears to be more reflective of the nature of substance abuse than of treatment programs per se. We have begun piloting a two pronged intervention to increase engagement, and thereby widen the applicability of BTSAS. The approach involves: a) a time-limited case management technique referred to as a Critical Time Intervention, to help develop a relationship between the treatment team and the patient and to help him overcome structural obstacles to treatment; and b) a time limited psychoeducational intervention for Concerned Significant Others (CSOs) (family members, friends), that aims to enlist them as partners to help connect the patient with treatment. We propose to investigate the effects of this intervention for increasing engagement and treatment retention in BTSAS.

The specific aims of this proposed project are: 1. To determine if BTSAS is more effective in reducing drug use than a manualized treatment as usual in a well-controlled clinical trial (a NIDA Stage 2 study); and 2) To determine if a combined CTI and CSO intervention can increase treatment engagement and reduce attrition in BTSAS. Secondary aims include: a) to determine if CTI/CSO increases session attendance and improves drug use outcomes for BTSAS; and b) to examine the effects of CTI for patients who do not have a participating CSO.